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ABSTRACT

A discussion is presented of the problems inherent in attempting to develop a national policy for health education. Health education is defined as any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health. The major difficulties facing developers of national health education are identified as general lack of faith on the part of the public of any government-sponsored program, and distrust of television, a medium that could be an effective tool in information dissemination. (JD)

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National Policy in the Promotion of Health

Lawrence W. Green

My purpose today is not so much to address what governments can do, but more what governments cannot do. Recognizing the necessary limitations and the potential of government policy, I have five paradoxes, two cycles, three definitions, and several proposals. If you can keep track of that, you will have followed my outline.

Paradox No. 1 -- Every decision involves risk, but then not to decide is also to face risks. It is in the nature of policy, and in the nature of decisionmaking--indeed, it is definitional--that a decision involves risk. Whichever way you turn, sideways, up or down, there are certain risks and uncertain risks.

Paradox No. 2 -- Every decision requires a choice between competing values. Every time we ask people to make a choice, especially in relation to health policy matters, we are asking them to choose between values each of which usually has a degree of attraction, a certain implied benefit or value to them, and it becomes a choice then between competing risks and competing values. You cannot have all things all ways. You cannot have your cake and eat it too. So policy, as Victor Fuchs has helped us understand, requires choice, and choices will have to be made between competing values as well as risks.

Paradox No. 3 -- Today's solution may be tomorrow's problem. The corollary of that is that today's problems may become tomorrow's

solution, as in the case of people who find that taking a little bit of alcohol now may be helpful rather than harmful.

Paradox No. 4 -- My solution may become your problem. What represents a solution for some people may become a problem for others. We solve the problems of some people and create problems for others in the process. If we understand that, we shall be much more careful about seeking advice and consent in the policymaking process.

Paradox No. 5 -- A public solution is only as viable as the public perception that it is doing them some good. No matter how important the program may be in objective terms, if the public does not have feedback from the policies that they have consented to, if the public does not understand why it is that we are regulating or coercing or persuading them to do required things, to participate in certain activities, to cooperate in certain programs, they are not likely to support our policies for long. This is a paradox for public health, health education, health promotion, and prevention, because most of the prevention and health promotion initiatives do not eradicate easily perceived problems. Most of them have to do with expected problems, problems that might develop in the future, and so to expect people to perceive the benefits readily is to expect of them a degree of foresightfulness that can only be attained through an educational process.

To cope with these several paradoxes in policymaking, we need two things -- we need facts and we need a process. We need a process of information dissemination and decisionmaking that allows relative risks, relative benefits, values and time frames to be weighed by an educated

public. We need a process that will allow the public to participate in as decentralized a way as possible in the formulating of policy. Where are we going to get the facts and how will facts be related to policy in health education?

The Information Cycle

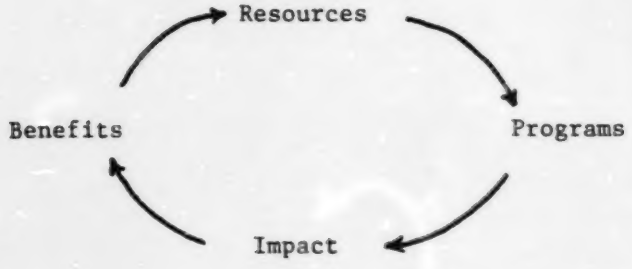
Let me acquaint you first with a historical fact that Marshall Kreuter and I discovered in relation particularly to school health but which applies more generally to health promotion.[1] It is a poverty cycle that started with inadequate support in the past, which resulted in programs that were diffuse and of questionable quality; these in turn have resulted in modest and scattered impact which, in turn, results in benefits that are either undetectable or nonexistent. Without demonstrated benefits of health education, it fails to get much more support and so the cycle becomes continuous. It is a cycle that is only beginning to be broken.

How do facts relate to the cycle? Where can facts intervene to affect this poverty cycle of health education? At the first level, where programs are poorly developed, facts can provide process evaluation; they can help us to become clearer, more explicit, more definitive about the goals, the purposes, the methods, and the procedures of health education. Quality assurance, peer review, and clarification of the goals and methods of health education are the kinds of facts that we need to document clearly so that we can understand what it is we are doing at the very least, how we are doing it, and with what level of

quality are we delivering health education. Quite independent of its effect, at least we ought to be able to document what we are doing, how we are doing it, and how proficiently we are doing it as judged by professional standards of quality.

At a second level, where the immediate effects of programs are unknown, we are in a position of contributing facts to policy by means of impact evaluation. What are the immediate outcomes of health education? What effects are we getting in the short run in changes in the knowledge, attitudes, beliefs and values that motivate health behavior, what changes in the organization of health services that will enable people to get at them; what changes in the social climate, support and reinforcement of behavior change? Those are the immediate outcomes, including some short range behavioral changes, that we should be able to document in programs.

Figure 1. The information cycle in health programs.



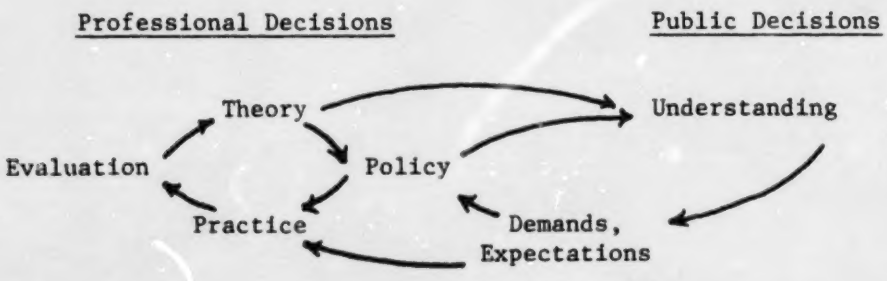
The third kind of facts needed to advise policy is information about the outcomes of health education in the longer run. These include longer lasting behavioral change, the maintenance of changes

in lifestyle as well as in the structure of services and the delivery of services in the environment, and also the health outcomes themselves. What improvements can be detected in health or in social problems as a result of health education programs and interventions.

The Decision Cycles

If we could provide factual information at those three levels, policy could be much better advised. But all the facts in the world are not going to advise policy adequately unless we also have a process that allows people to participate in weighing those facts, in assessing the relative benefits, risks, values and time frames in relation to the problems they perceive and the actions we recommend. And so we have another cycle, actually two overlapping cycles, that have to do with policy. One is a cycle of professional behavior and organizational behavior, the behavior of providers and deliverers of services. In health education, this cycle includes policy that influences practice which influences research and evaluation, which influences information and theory. Some of these also influence training which influences each of the others and back to policy.

Figure 2. The decision cycles in health programs.



On the public side, there is another cycle that overlaps with the professional decision cycle. The public begins with certain social concerns. These concerns lead to demands for improvements in the quality of life. Those demands result in certain policy initiatives through elected legislators, representatives, and officials. Those policy changes are also influenced by facts -- information and theory that come out of the professional domain -- the research, the state of the art, the literature that tells us what works, what is possible, and what has been the previous experience with policy in this area.

Policy, in turn, influences practice, the delivery of services, the delivery of health education. Practice is influenced also by the public. As professionals we are directly influenced, not just through policy, but by our interaction with the public. The doctor interacting with the patient, the nurse interacting with the patient, the health educator in the community interacting with the students or the citizens of that community -- each influences the way health services are delivered. Practice, in turn, results in the satisfaction of certain needs which results back into a modification of the public's perception of those needs, their expectations will be modified, and policy will be supported or contested. Practice sets up a situation where we can conduct research and evaluation to determine the effects of our methods or techniques. Research and evaluation feed into the knowledge pool, adding facts to theory, which in turn will affect training, policy and public understanding. If we can make the information known to the public we can

influence the public's understanding of policy issues which will effect, in turn, their concerns and demands.

Issues in Policy for Health Promotion

As a foundation for an understanding of the paradoxes in policy-making and decisionmaking, the foregoing models identify the actors, issues, and needs involved in policy. Let me now address a couple of the issues that seem to be very much in the front of your attention at this conference. If we are going to turn medical care systems around in a way that puts more emphasis on prevention and health promotion, we must expect the consumer, the patient, or the citizen to play a larger role in health care, both within and outside the system. To what extent can we reasonably place responsibility on individual citizens, not just in relation to changing their own lifestyle, but in relation to their participation in policymaking, their participation in self care, and their participation in affecting the environment? We run the risk of blaming the victim if we abrogate the entire responsibility for health to the individual.[2]

In attempting to communicate the potential economic benefits of health promotion to the medical establishment, the legislative establishment, the government establishment, and to the consumers, it may be interpreted wrongly as a tool of a reactionary establishment. We may be accused of believing that health education's main function is to save money for the system and the public be damned.

When we define health education in such a way that behavior is a necessary step between learning and health improvement, we are

sometimes accused of having sinister propagandistic intentions. Behavior is the major determinant of health that we can influence directly out of health education. The point that seems to get us in trouble with this representation is believing that the only influence on health is behavior, and interpreting behavior rather narrowly to mean lifestyle.

I have previously defined health education as any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health. The key terms in this definition are underlined and one of them is behavior, but I will draw your attention also to "voluntary," to "combination," and to "design," because those are the other stumbling blocks in an adequate understanding of health education. First, let me focus on behavior. What are the causes of health? What are the determinants of improved or threatened health? They fall into three broad categories -- environment, behavior, and medical care. Medical care is getting a bad reputation these days as not a very important determinant of health, even though the public in some countries were led to believe that it was the primary determinant of health. Increasingly, behavior has been regarded as the major determinant, but attention is also being given to environment -- the work environment, the physical environment, the social environment and the economic environment. Now we can ask, how does behavior relate to the other determinants of health, where does health education fit? Behavior is not only a direct determinant of health, but it is also an indirect determinant of health to the degree that behavior can influence the environment and can influence medical care. Here is where the

health education link with policy begins to emerge more as propaganda or blaming the victim. We do not need to think of behavior just as lifestyle -- those modifications that we expect people to make even though they may not be able to afford to make them -- but they also include behavior directed at the medical care system and at the environment -- collective behavior, social action, the behavior that people can exercise collectively or individually to influence the health care system, or to guard themselves against environmental risks. Behavior can and should influence health directly as well, through preventive activities, the so-called lifestyle activities, and through self-care in the face of symptoms. Behavior can influence health through medical care by relating patients more effectively to the medical care system in health examinations, in illness behavior and sick role behavior, but also in policymaking. An activated, concerned, and knowledgeable public can participate more effectively in the decisions that tend to be made by doctors, nurses and politicians concerning personal and community health issues, as well as national issues such as universal health insurance.

If we understand that behavior can influence health through all three of those paths, then I think we see a much larger role for behavior than just lifestyle, and therefore a much larger role for health education than just affecting lifestyle behavior. Health education will make its major contribution, vis-a-vis other technologies of change, in facilitating voluntary changes in behavior, to be sure, but we should not regard that behavior narrowly as individual lifestyle change. Health education, as

part of health promotion, is directed as much at groups, organizations and communities as at individuals; and it is concerned as much with environmental, economic and social changes influenced by behavior as with lifestyle habits and preferences.

Government vs Other Channels

What should be the role of government and what should be the role of other agencies in promoting health? When we concern ourselves with government's role in health education, we have to ask how people perceive the government and what people's confidence in the government will be. People do not always regard the government as the most credible source of communication and advice on health matters. What seems to have happened since the late 50's in the United States is that public confidence in government as an agency of change or as a servant of the people has been eroded. Less than 40 percent of the population may at some point perceive the government as a credible source.

Information can be centralized but education cannot. The government can develop knowledge, can store it, can organize it, can retrieve it, and can make it available to decisionmakers, but a government by and for the people cannot long make decisions for people or it will soon become a plutocracy or an autocracy. Decisionmaking must be made as decentralized as possible.

What about the mass media? If the government cannot do it perhaps the other broad-based approach we can take to health is the mass media. Unfortunately, a similar trend is notable although not quite so dramatic

in public confidence in the media as a source of information in the United States. The percentage of people who have hardly any confidence in the people running television between 1973 and 1978 has increased and the percentage of people having a great deal of confidence has decreased. It is in the very nature of mass media that they have to produce a message and they have to communicate it in such a way that it will appeal to some magical medium of the public. The ability to communicate in a tailored, individualized, appropriate way for subgroups in the population is limited with mass media because as soon as the mass media begins to do that they lose a large segment of the audience. The survival of mass media depends on their ability to communicate broadly to the widest possible audience. Not only do the messages tend to be geared to some magical medium that is not appropriate to 40 percent of the population on either end of a normal curve, but the people themselves who regularly attend to the media begin to define their own problems in relation to that average. We end up with stereotypes about health and about behavior because they are communicated through the mass media in a way that is applicable to some average person. Large masses of the population begin believing they have hypoglycemia or a middle life crisis. Problems get defined in some insipid, average way and the particular problems of subgroups, of cultural groups, of geographical regions, get glossed over.

Worse is the tendency for some mass media to convey a great deal of misinformation, negative role modeling, advertising of junk foods, especially for children, and violence.

Now I do not mean to portray television or the mass media in general as an inappropriate resource for health education. I simply want to offset the simplistic thinking of some who believe that it's the magic bullet answer to all of health education's problems. In fact, I believe that mass media and television in particular represent a great untapped resource for health education, but not in motivating people as Madison Avenue would have us believe they could do if only we would give them the money from the health education budget; not in changing people's behavior, but more likely in reinforcing and supporting behavior that is being changed through more decentralized local processes of decision-making and change.

The last limitation that I see for the mass media is that television in particular, and the mass media in general, tend to portray health matters in the context of high drama, high medical technology, heart transplants, bypass valves and other advanced technological and heroic interventions that only apply to a small proportion of the total population. To the extent that they do that they give the public a false belief that technology will save them no matter how they abuse themselves in the meantime, no matter what else may be going on in the environment. The public is thereby lulled into a false sense of security about their responsibility to themselves or to their environment in trying to affect change.

There are other problems with centralized decisionmaking and communication in health. One has to do with values -- whose values for

whom? If the government, especially a centralized government, is to make decisions centrally on health matters, especially behavior in relation to health, to what extent can that centralized government reflect the wide range of values of the subgroups in the population? Let us look at values particularly in relation to risk-taking which is where values come very largely into play. What is risky behavior, and who is to tell me that my behavior is too risky? At one extreme we have suicidal behavior, that behavior which is so dangerous in relation to the benefits that might be derived from it that anybody who engages in it is engaging in almost certain self-destruction. At the other extreme, however, I think is a neglected range of behavior which is pathologically safe behavior, behavior that is so affected by fear of risk regardless of the potential benefits that people will not leave their homes, will not take any chances, will take no risks in life and therefore their quality of life probably suffers as much as the person who is taking suicidal risks. Between those two extremes, the suicidal and the pathologically safe, is a wide range of behavior, some of which is dangerous and some of which is ultra-safe, and even between those two moderate extremes is a normal safe range of available behaviors which yield modest benefits relative to the minor risks that people have to take. But people have to take some risks in order to gain benefits.

Now what benefits do people want in life -- this is where values come to play so prominently and where I think it is so dangerous for national government in particular or any federated or highly centralized

government to try to make these decisions for people. This is where I believe health education has its largest role to play. Helping people to understand risk-benefit ratios, helping young children to think in probabilistic terms, helping people to sort out the competing risks and competing values that they have to assess in making decisions in their daily lives. To the extent that centralized governments can assist in developing the knowledge base so that people will have the information they need to make those choices, I think to that extent centralized governments have a major role to play in health education. But to the extent that those decisions are made by that centralized government, prefabricated for the individual, to that extent I think the centralized government has overstepped its useful and even safe role in health education.

Another thing we have to understand about risks is that people will take a different amount of risk relative to the benefit depending on whether the behavior that is at issue is voluntary or involuntary, whether the risk is controllable or not controllable, whether it is new or familiar, whether it is known or unknown, whether it is delayed or immediate. In relation to each of those contrasts determining how much risk people are willing to take, there is a differential that happens to work to the disadvantage in many ways of what we are trying to accomplish in health education. To the extent that the benefits of health education are more distant rather than more immediate, the risks less controllable, less familiar rather than familiar, to that extent we have a more arduous task in health education.

One other issue that government must grapple with in health is the question of incentives versus regulation. Should the government, where it does have to play a role in behavior, do so with the carrot or the stick. The contrast between the policies of Indira Gandhi and her successor, Prime Minister Desai, in the family planning program of India, illustrates the dilemma. Gandhi had put a great deal of emphasis on the stick because of the urgency of the population problem. Her successor, to relieve political pressure, put more emphasis on the carrot and less on the stick. It is my personal view, and I think this is shared by a nervous Congress when it legislates on health, that the stick should only be used when the behavior in question influences the health of others rather than of that individual. To the extent that behavior is only a risk to the individual, we should maximize the carrot rather than the stick. When the behavior threatens the health of others, we have to maximize the stick more and more, we have to regulate rather than simply provide incentives. It becomes less and less a matter or health education once the decision to regulate has been made. But the decision to regulate, I think, must involve health education because people must participate in deciding whether we should regulate, whom we should regulate, and how we should regulate. If we have too little participation of people in that decision then we will be regulating coercively and without adequate representation of the public.

Conclusions

The foregoing analysis implies a set of definitions for health, health education, health promotion, and health behavior. These are

words that are included in the legislation that mandates the office that I have been asked to direct. Some are words that are included in the title of the office, so I have no choice but to come to grips with the distinctions I will intend by the use of these terms. Let me define health as the ability of a system (a cell, an organ, an individual, a family, or a community) to adapt its equilibrium in response to change. Health behavior then is personal adaptation to anticipated challenges or risks to health. Health education I defined earlier as any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health. That then leads me to define health promotion as any combination of health education and related organizational, economic and political interventions designed to facilitate behavioral and environmental changes conducive to health. These definitions are consistent with the activities and the efforts that government can deploy in the name of health education and health promotion, as illustrated in Figure 3.

It will be the task of health professionals to assure that their governments are held accountable for these activities.

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Figure 3. The context of health promotion.